LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la.info

STANDARDS OF CARE
COMMITTEE MEETING MINUTES
August 4, 2011

MEMBERS PRESENT	MEMBERS ABSENT	HIV EPI AND OAPP STAFF	COMM STAFF/ CONSULTANTS
Angélica Palmeros, *Co-Chair*	Anthony Braswell	Angela Boger	Kathleen Clanon
Fariba Younai, *Co-Chair*	David Giugni		Jane Nachazel
Mark Davis	Terry Goddard		Glenda Pinney
Louis Guitron	Jeffrey Goodman		Diane Tan
Bradley Land	Carlos Vega-Matos	**PUBLIC**	Craig Vincent-Jones
Jenny O'Malley	Jocelyn Woodard/Robert Sotomayor	Jason Wise	Adriane Wynn
Juan Rivera			

CONTENTS OF COMMITTEE PACKET

1) **Agenda**: Standards of Care Committee Agenda, *8/4/2011*
2) **Memorandum**: Consolidation of Standards of Care, *8/2/2011*
3) **PowerPoint**: HIV Primary and Specialty Care, 8*/4/2011*
4) **Press Release**: FAIR's Board of Director's to Senate and House Appropriations Committees: Cut HIV/AIDS Funding, *5/25/2011*
5) **Editorial**: Human Immunodeficiency Virus *Is* (Once Again) a Primary Care Disease, *4/25/2011*

1. **CALL TO ORDER**: Dr. Younai called the meeting to order at 9:40 am.

2. **APPROVAL OF AGENDA**:
   MOTION #1: Approve the Agenda Order **(*Passed by Consensus*)**.

3. **APPROVAL OF MEETING MINUTES**:
   MOTION #2: Approve the Standards of Care Committee meeting minutes **(*Postponed*)**.

4. **PUBLIC COMMENT, NON-AGENDIZED**: There were no comments.

5. **COMMISSION COMMENT, NON-AGENDIZED OR FOLLOW-UP**: There were no comments.

6. **CO-CHAIRS' REPORT**: Mr. Guitron confirmed he would be leaving the Commission in September due to school demands.

7. **STANDARDS OF CARE**:
   A. **Consolidation of Standards**:
      - Ms. Vincent-Jones noted one of the Commission's Health Care Reform (HCR) goals is to promote use of its standards by other systems of care. The current 28 standards may be an impediment for systems looking for more streamlined standards. As a result, the Committee agreed to start consolidating standards that can be addressed concurrent as publication moves forward. The accompanying memorandum proposes consolidating 13 service categories into six as follows:
        1. **Linkage to Care (LTC) Services**: Combining Early Intervention Services (EIS), Outreach and Treatment Education (TE) resolves the issue of whether to fund TE without clear linkage to medical care. There has also been difficulty

identifying the difference between EIS which includes an Outreach component and Medical Outpatient (MO). In the new configuration, EIS becomes a combined program model with MO and LTC.
- ➲ Add HIV Counseling and Testing Standard of Care to LTC.

2. **Housing Support(ive) Services**: Case Management (CM), Housing and Direct Emergency Financial Assistance (DEFA) are a natural combination since DEFA for housing would go through CM, Housing. Some of DEFA may include prescriptions, etc., which would be part of HIP/C-S.
   - ➲ Use "Supportive" to match HOPWA terminology.
3. **Benefits Support**: Benefits Specialty is a logical match for Health Insurance Premiums/Cost-Sharing (HIP/C-S) since HIP/C-S provides assistance for health insurance, premiums, co-pays, etc. and would be accessed through Benefits Specialty, similar to the combination of services under Housing Supportive Services.
4. **Home-Based Care**: Combining CM, Home-Based and Home Health Care, which currently is unfunded and has no standard of care, addresses the issue of where to place Home Health Care should it be developed.
5. **Long-Term and Palliative Care**: Combining Skilled Nursing and Hospice Care will resolve the perennial issue of whether to address these overlapping services separately or jointly.
6. **Mental Health Services**: Mental Health (MH), Psychiatry and MH, Psychotherapy were traditionally kept separate as the former was associated with clinical services and the latter with psychosocial services. They will inevitably be offered in tandem in the context of a medical home under HCR, so coordinating them now is beneficial.

- ➲ Add **Substance Abuse Services**: Combine Substance Abuse (SA), Treatment and SA, Residential.
- ➲ Prioritize completion of Special Populations as soon as feasible.

MOTION #3: ***(Younai/Land)*** Combine standards as detailed above **(*Passed by Consensus*)**.

B. Medical Care Coordination (MCC):

1. ***Commission/OAPP Comparison Matrix***: Finalization of previously agreed matrix postponed.

C. Medical Outpatient (MO):

1. ***Medical Marijuana***:
   - Mr. Vincent-Jones noted Dr. David Martin, Director, HIV Mental Health at Harbor-UCLA Medical Center, presented on the need for better guidance how to regulate the use of medical marijuana in the clinical context at the 11/18/2010 Commission meeting. Medical marijuana will need to be addressed as part of the MO Standard of Care, so it would be helpful to have him back.
   - ➲ Invite Dr. Martin to present at the 10/6/2011 Committee meeting.

8. GRIEVANCE POLICY AND PROCEDURES:

A. Pol. #05.8001: Grievance Procedures:

- Mr. Vincent-Jones requested guidance on escalation triggers for the three HRSA-required steps from conflict resolution to mediation to binding arbitration. The most common reasons for a Commission grievance are that either it or the administrative agency did not follow Commission process, e.g., allocation procedures. Remedies cannot be retroactive.
- Dr. Younai said research indicates that the party that pays for arbitration wins 90% of the time. Mr. Vincent-Jones said the County has a third-party mediation service available to the Commission, but an arbitrator would need to be hired.
- ➲ Agreed that the grievant will hire an arbitrator, if needed, with Commission consent and will pay for the arbitration.
- ➲ SOC agreed on the following triggers for grievance escalation: process not followed, level of harm, new information.
- ➲ Mr. Vincent-Jones will consult with Diane Burbie on her insights from the County Human Rights Commission regarding any additional triggers.

9. EVALUATION OF SERVICE EFFECTIVENESS (ESE): Mr. Vincent-Jones noted Ms. Tan converted the ESE into the County's SurveyMonkey-like software, VoicI. Postponement was frustrating, but fruitful as ESE now provides a pre-HCR benchmark to evaluate migration.

10. COST IMPACT/FEASIBILITY SUBCOMMITTEE: The Committee agreed to end the Subcommittee and absorb the work back into the SOC Committee.

11. PRIORITY- AND ALLOCATION-SETTING (P-AND-A) DIRECTIVES:

A. Substance Abuse Consistency with HRSA:

- Mr. Vincent-Jones reported a question arose during last year's P-and-A process regarding whether the Commission's Substance Abuse services were consistent with HRSA's definition. A directive was issued to resolve the question.
- ➲ OAPP will review the matter and report back at the 9/1/2011 SOC meeting.

12. HIV PRIMARY AND SPECIALTY CARE:

- Dr. Clanon, Clinical Director, Pacific AIDS Education and Training Center (PAETC), noted the Commission is at the forefront of debate on whether mainstreaming PLWH into standard primary care will increase access under the Affordable Care Act (ACA) or dismantle necessary care. Dr. Mitchell Katz, Director, Department of Health Services (DHS), brought renewed attention to the issue with his 4/25/2011 article in the *Archives of Internal Medicine* of the American Medical Association.
- Dr. Clanon said primary versus specialty pertains more to the model of care than staff providing it, e.g., Dr. Katz references a co-management model in which routine care is provided by a primary care practitioner with referral to an HIV specialist if there are questions about HIV medications or an HIV complication, much like a cardiology referral for a heart patient.
- There are currently no standards of care for a co-management model (e.g., when to refer to an HIV specialist).
- The medical home model can be applied to co-management or simply mainstreaming PLWH into the general care system.
- Objections to moving to primary care are: HIV experts provide better care, primary care providers have little HIV training and lack interest in improving, PLWH need a special model to address affected populations, and stigma. It is also hard for PLWH to obtain health insurance though that may change with HCR. Access is key as HIV is incurable and communicable.
- A 2005 study in the *Archives of Internal Medicine* compared accurate ARV prescription, correct order and use of resistance tests, and performance on a set of health care screening tests among non-expert generalist physicians, 54.7%; expert generalist specialist physicians, 60.2%; and infectious disease physicians, 62.4%. The study showed higher mortality for those with less experienced practitioners, but care focused on opportunistic infections and cancers so the study's findings may be obsolete. The author is working with the CDC to update the study though lower mortality rates make identifying a sample difficult.
- A May 2004 survey of 729 first-year medical residents asked if their training prepared them to practice HIV medicine. Responses were: no, 51%; unsure, 26%; and yes, 23%. Such practitioners are likely to be unprepared for PLWH clients.
- Clinics can also be unprepared. The Center for HIV Care and Prevention studied transition of care from a 25-year-old Santa Rosa, California clinic supported by Ryan White (RW) Parts A, B, C and County funds to three Community Health Centers (CHCs) in July 2010 based on declining Federal, State and County support. CHCs had difficulty integrating services such as case management and nutritional counseling. Providers expressed low confidence in their expertise while administrators were reluctant to absorb an expensive population. HIV specialist physicians were reluctant to work in a general clinic.
- Problems fueled by stigma were undetermined, but an August 2011 Los Angeles study of 208 HIV+ Latinos on discrimination in their physician's office found nearly 40% reported discrimination due to HIV or ethnicity and over 45% due to sexual orientation.
- Dr. Clanon felt in the long run such issues can and will be addressed, but the transition for current patients will be hard.
- Mr. Guitron reported the Los Angeles Gay and Lesbian Center (LAGLC) began as an HIV-specific clinic and later expanded to a Federally Qualified Health Center (FQHC) look-alike model. He felt it easier to expand in that fashion as the quality of care is already high.
- Arguments for moving to primary care are: PLWH needs have changed with an aging population and better HIV treatment; mainstreaming offers a larger pool of services, e.g., for medical and social needs associated with aging; stigma has declined over time; care would be more fiscally sustainable; and prevention would improve, e.g., as primary care providers become more alert to the need for routine testing and roadblocks to contact tracing are removed.
- A 9/1/2005 comparison of general internists seeing HIV patients in a general medicine clinic and infectious disease specialists in an HIV clinic found the former more comfortable treating diabetes, 98% to 57%; hypertension, 98% to 73%; hyperlipidemia, 98% to 71%; and depression, 49% to 33%.
- Fiscal equity is another issue, e.g., all CHC and similar federal programs receive $4 billion versus $2 billion for HIV.
- HRSA is also emphasizing CHC settings in grants and via webinars and encouraging HIV-specific clinics to apply for FQHC certification, suggesting change is coming. Resistance at all costs or preparation for the likely future are the basic options.
- Dr. Younai felt people underestimate the cost of integrating PLWH into the broader system. Dr. Clanon agreed that is another argument against a primary care model. Regarding current line items for specialists, she noted Alameda County is providing additional funding, but is also enforcing strict screening and referral to manage demand and availability.

- If integration of HIV into primary care goes forward, then standards will need to be established, e.g., for a regular physician at a clinic or one that rotates among clinics.
- The HIV workforce itself is also aging. Research shows medical students gravitate toward specialties they were exposed to in training, so various ways to increase exposure should be fostered. The University of New Mexico Project Extension for Community Healthcare Outcomes (ECHO), e.g., uses telemedicine distance learning to present cases and build skills.
- Mr. Vincent-Jones noted the pro/con approach could be used in planning. Dr. Clanon agreed that her goal in working with the Consumer Caucus was to develop a response to Dr. Katz's editorial. One approach is to support a bridge arrangement.
- She noted the Santa Rosa staff experienced HIV clients as more demanding than others. That is understandable based on a history of having to demand services, but the general healthcare system normally offers a lower level of service, e.g., with longer wait times and fewer ancillary services. That is an opportunity to improve general care, but would require funding.
- Ms. Nachazel noted clinics may need to improve services for all or HIV- patients will be upset with the different levels of care.
- Ms. O'Malley noted Kaiser never follows-up on her appointments, but that would be dangerous for PLWH. Mr. Vincent-Jones said Kaiser distinguishes between average clients and those with chronic health issues for whom they are proactive.
- Dr. Davis felt many patients will need to be re-educated for the primary care system, e.g., most of his patients expect to be seen promptly with or without an appointment. Ms. O'Malley agreed. Both noted their own care system is vastly different.
- Dr. Younai noted standards are written to identify items to do, but do not address transition. Dr. Clanon reported there was a qualitative study of some 25 New York providers on what they would need to make a transition work. They agreed on three items: case managers, skills education and on-going mentoring to learn how to balance responsiveness to client needs with reasonable operating rules. The HIV community must actively participate in the transition to ensure care.
- Mr. Vincent-Jones said the HIV system has fostered a sense of consumer expectation that they will be treated differently. The Consumer Caucus is leading the Commission discussion because consumers must participate in and lead the change so the transition does not devolve into conflict between providers and consumers despite some loss of service.

➲ Dr. Clanon will develop a document on the issue with the Consumer Caucus and bring it back to the 9/1/2011 SOC meeting.
➲ Mr. Vincent-Jones will also bring the document forward to inform the RW Reauthorization Task Force.

13. AETC REPORT: There was no report.

14. NEXT STEPS: There was no additional discussion.

15. ANNOUNCEMENTS: There were no announcements.

16. ADJOURNMENT: The meeting adjourned at 11:45 am.